Report to the
House of Representatives Appropriations Subcommittee
on Health and Human Services, and
Senate Appropriations Committee on Health and Human Services

On

Mental Health, Developmental Disabilities and Substance Abuse Services Community Services Funds for State Fiscal Year 2012

Session Law 2011-145, Section 10.11(f)

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North Carolina Department of Health and Human Services,
Division of Mental Health, Developmental Disabilities,
and Substance Abuse Services

Report on Mental Health, Developmental Disabilities and Substance Abuse Community Services Funds State Fiscal Year 2012

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (Division) was instructed to implement various components related to Community Services Funds as appropriated to Local Management Entities (LMEs) for State fiscal year 2011-2012. This report outlines the methodology for the implementation of the funding reductions to:

- reduce Community Services Funds by twenty million dollars ($20M)
- reduce Community Services Funds by twenty five million dollars ($25M) based on the available fund balance reported by the LME's 2010 fiscal audit and estimate unspent reserves held by single county LMEs;
- implement a co-payment for all mental health, developmental disabilities, and substance abuse services based upon the Medicaid co-payment rates; and
- develop a set of standardized covered benefits for recipients of LME Service Funds that will become the only services paid for by community service funds through the LMEs.

Community Services Reductions

METHODOLOGY:
The Division reviewed the reported LME fund balances as of June 30, 2010, as directed by S.L. 2011-145, Section 10.11(d). Fund balance designations reflected that the funding was labeled as undesignated and/or reserved for various purposes. The Division undesignated the funds for purposes such as administrative functions, technology enhancements, equipment replacement, and other non-descriptive general categories across all LMEs. A portion of the unreserved, undesignated fund balance was allowed to remain with the LMEs to supplement funding of services without impairing the LMEs fiscal stability. The enclosed chart depicts the pro rata share of each LMEs reductions and the ending balance allocation for the fiscal year.

IMPLEMENTATION
In an effort to comply with the $25 million fund balance reduction, per S.L. 2011-145, Section 10.11 (a) – (f), an agreed upon plan of action was developed between the Division and the Local Management Entitles to initiate an approach to efficiently managed the reporting and expending of the LMEs' fund balance and State appropriated community funds..

The ***Community Funding Efficiency Plan*** as implemented is outlined below:

- The LMEs will
    a. Reclassify a portion of their reported State Non-UCR expenditures [beginning on July 1, 2011] in an amount equal to or greater than the LME's allocated responsibility, per the Division's 2011 Allocation Letter, for the $25 million in fund balance expenditures mandated by the General Assembly. This amount will be reclassified to show it was expended from fund balance and will not count

towards the LMEs earnings of their Single Stream allocation. Note: A separate process will be applied for the Beacon Center.

b. The same Non-UCR reclassification will apply for those LMEs that committed at the beginning of the fiscal year to spend some of their fund balance dollars toward the $20 million "encouraged" reduction from fund balance.

- A new category will be included on the quarterly Fiscal Monitoring Report for the LMEs to report all related expenditures by the LME for the implementation and/or conversion to a Managed Care Organization (MCO).

- The LME Performance Contract for FY 2012 will be followed for payment and settlement of single stream funding. The Division will track each LME's reported earnings through shadow claims and non-UCR monthly expenditure reports. If the LMEs' earnings through shadow claims and non-UCR expenditures are less than 85% of the LME's single stream payments at the end of each of the remaining months in the fiscal year, the LME's single stream payment will be withheld until earnings and reported expenditures reach at least 85% of payments made.

- The Division will compute the amount each LME is required to earn through shadow claims and non-UCR expenditures for FY 2012, in accordance with the contract. Those LMEs that have not earned 7/12ths of the required amount as of January 31, 2012 will be contacted to determine why earnings are not on track. Funds may be reallocated from under-earning LMEs on a one-time basis this fiscal year in accordance with Section 10.8(d) of HB 200.

MONITORING AND IMPACT:

A monthly financial management report was used to examine the LME expenditures and any appropriations of fund balance to their operating budget. The legislation encouraged the LMEs to spend fund balance to minimize their share of the $20M reduction to services.

The Division conducted a survey in March 2012 of the LMEs to determine the impact of the $20M reduction within the LMEs' catchment area. LMEs with insufficient fund balance to cover the reduction reduced their budgets to reflect the funding cut. The following information reflects the resulting impact of the reduction.

$7M of the $20M was replaced by other funds.

- 8 of the 23 LMEs (35%) backfilled their share of the cut with their Fund Balance (or in one case, County funds).
    - 3 of these LMEs indicated that this reduced their Fund Balance so low that they will have to cut services in SFY 2013 if funds are reduced again.

$13M of the $20M was cut from service funds.

- 15 of the 23 LMEs (65%) reduced their budgets to reflect the allocation reduction.
    - 9 LMEs indicated they had to reduce services or deny services to consumers; and
    - 6 LMEs indicated they did not cut services to current consumers.
- The 15 LMEs utilized a number of techniques to reduce expenditures:

- 6 implemented more restrictive eligibility criteria;
- 5 modified their benefit plan to continue serving clients but cut provider reimbursement;
- 3 implemented a rate reduction (in addition to Medicaid's rate reduction);
- 8 decreased the maximum amount of services that could be provided in contracts with one or more providers;
- 4 terminated contracts for services with one or more providers; and
- 5 found or required program efficiencies without decreasing services in one or more areas or service contracts.

Impact on consumers varied across LMEs.

- The 15 LMEs that reduced their budgets estimated the impact as follows:
  - 2,175 persons were denied services, who would have gotten them if these funds had been in place;
  - Over 8,000 consumers received services at a reduced level; and
  - 252 contracts with providers were either reduced or terminated (the number of agencies is less, as some have multiple contracts).
- Across the State, there are over 8,000 persons with intellectual and developmental disabilities (IDD) waiting for services, with over 3,500 of these not receiving any services, based on LME reports.
- For most mental health and substance abuse services, the number of people served by State funds was lower in December 2011 than in December 2010, based on shadow and paid claims reported by the LMEs through February 2012. The exception was a slight increase in the number of people receiving State-funded substance abuse services (Substance Abuse Intensive Outpatient Program (SAIOP) and Substance Abuse Comprehensive Outpatient Treatment Program (SACOT)), which is an area of service the Division has been actively working to increase.

Co-Payment Process

Pursuant to N.C.G.S. §122C-112.1, the Division will implement a graduated fee co-payment schedule via administrative rule. In keeping with that intent, the Division has initiated rulemaking to ensure that the requirements associated with the implementation of a standardized graduated fee co-payment schedule, to be used by the LMEs and service provider agencies, are met. Implementing the graduated fee co-payment schedule via rules will ensure not only standardization of the co-payment process but also consistent implementation of the co-payment guidelines. This process allows for public input into the methodology for computing and the expectations associated with the implementation of the co-payment fee.

S.L. 2011-145, Section 10.11.(c) mandates that the co-payment schedule be based upon the Medicaid co-payment rates. Those rates are set forth in the North Carolina Administrative Code; however, that rule does not address mental heath, developmental disability, or substance abuse services. Interestingly, the rule specifically excludes copayments for the following: services provided in state owned mental hospitals and services provided to persons less than 21 years of age and those provided to residents of Intermediate Care Facilities (ICF), Intermediate Care Facilities for Persons with Mental Retardation (ICF-MR), Skilled Nursing Facilities (SNF), and Mental Hospitals.

The Division will assess a co-pay of three dollars per service visit to all consumers of non-residential services for mental health, developmental disability or substance abuse services, whose gross family income is equal to or greater than three hundred percent of the Federal Poverty Level guidelines and all subsequent revisions, as updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2). Consumers of mental health, developmental disability and substance abuse services whose gross family income is less than three hundred percent of the Federal Poverty Level shall not be charged a co-payment for any state funded services. As referenced herein, the term residential services refers to those state funded services *"provided in a 24-hour living environment in a non-hospital setting where room, board, and supervision are an integral part of the care, treatment, habilitation or rehabilitation provided to the individual.*

The proposed rule is being promulgated under the authority of the Secretary and has been presented as information to the Mental Health Commission's Rules Committee and the full Commission on Mental Health, Developmental Disabilities and Substance Abuse Services. The rule is awaiting creation, review and approval of the fiscal note by the Department of Health and Human Services and the Office of State Budget and Management.

Standardized Covered Benefits

The Division was also directed to consult with LME representatives as well as stakeholders to *develop a set of standardized covered benefits for recipients of LME Service funds that shall become the only services paid for by community service funds through LMEs*. (S.L. 2011-145, Section 10.11.(b)

N.C.G.S. §122C-2, *Policy,* requires all state and local governments to ensure, within available funds, that the following core services are available: (1) screening, assessment, and referral; (2) emergency services; (3) service coordination; and (4) consultation, prevention, and education. Community-based mental health, developmental disabilities and substance abuse services are managed through a network of local management entities that cover the state's 100 counties. These programs oversee and manage local services.

The Division has an ongoing process for the development of standardized service definitions for Community Based Services. A team of program and clinical staff, with best practice knowledge of each disability type, works with the LME and stakeholders to maximize the services within the LMEs' Benefits Plan. The standard service definitions are Division approved alternative services, that are reported as claims or "shadow claims" for the appropriate level of service delivery across each disability category.

The chart below outlines the pro rata share of each LMEs' reductions and the ending balance allocation for the fiscal year.

LMEs	PRO-RATA $25 Million Fund Balance Reduction	PRO-RATA Additional $20 Million Reduction	Total Community Service Funds Reduction	Total LME Community Services Funding after reductions
Alamance-Caswell	1,159,139	446,551	1,605,690	5,211,566
Beacon Center	6,467,234	467,060	6,934,294	196,060
Centerpoint	355,372	1,251,380	1,606,752	17,497,402
Crossroads	2,949,441	620,657	3,570,098	5,905,141
Cumberland	34,924	400,451	435,375	5,678,106
Durham	0	659,442	659,442	9,407,911
Eastpointe	577,696	676,377	1,254,073	9,071,812
ECBH	461,709	1,796,102	2,257,811	25,162,327
Five County	1,149,351	791,608	1,940,959	10,144,110
Guilford	1,288,848	920,859	2,209,707	11,848,564
Johnston	0	253,344	253,344	3,614,321
Mecklenburg	1,052,736	1,307,114	2,359,850	17,595,164
Mental Health Partners	956,572	644,831	1,601,403	8,242,900
Onslow-Carteret	496,105	281,666	777,771	3,522,279
Orange-Person-Chatham	954,257	612,198	1,566,455	7,779,650
Pathways	115,717	985,479	1,101,196	13,943,594
Piedmont	615,318	1,131,211	1,746,529	15,523,076
Sandhills	930,664	1,277,945	2,208,609	17,301,112
Smoky Mountain	632,415	1,676,205	2,308,620	23,281,120
Southeastern	2,460,827	561,968	3,022,795	5,556,481
Southeastern Regional	1,252,859	627,175	1,880,034	7,694,718
Wake	35,367	1,278,328	1,313,695	18,201,858
Western Highlands	1,053,449	1,332,047	2,385,498	17,950,199
GRAND TOTAL	25,000,000	20,000,000	45,000,000	260,329,471